471-000-221 Instructions for Completing Form DM-5, "Physician's Confidential Report." for the Preadmission Screening Process (PASP)

Use: Form DM-5 is used to secure the physician information needed to determine the kind and amount of medical care needed.

Number Prepared: One copy of Form DM-5 is completed.

Completion: Form DM-5 is completed as follows.

The facility completes these items:

Heading: Enters all the identifying information about the individual.

Item 1: No entry required.

Item 2: Reason for Referral: The effectiveness of information reported on this form depends largely on the phrasing in this section. A definite statement must be entered in this section.

The physician completes these items:

Items 3-15: Enter all appropriate information.

Signature: The physician signs and dates Form DM-5.

Distribution: For a negative screen for a Medicaid-eligible individual, the facility sends Form DM-5 to the nursing facility along with Form DPI-OBRA1. For a positive screen/Level II evaluation, the facility holds Form DM-5 for the OBRA Contractor.

Retention: Form DM-5 is retained for four years.

# PHYSICIANS CONFIDENTIAL REPORT

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

| Recipient/Payee, Relationship, Address | Name of Patient | | |
|---|---|---|---|
| | I.D./Social Security No. | Date of Birth | Sex ☐ Male ☐ Female |
| | Admission Date | Eligibility Date | Local Office |

Name, Address and Specialty of Examining Physician

1. To the Physician: The individual named above is an applicant for or recipient of assistance. Medical findings which you are asked to report on this form are used to determine eligibility for assistance and to plan for medical care and other services. It is important that your report be specific enough to indicate the kind and extent of disability and the treatment and services required. Attach additional pertinent information including hospital admission/discharge summaries, lab reports, consultative reports/letters, psych. reports and testing, etc.

2. Reason for Referral

Name - Title/Position _____ Date _____

| 3. Diagnosis (Related to present medical condition): | Date of Onset | Anticipated Duration |
|---|---|---|
| Primary | | |
| Secondary 1. | | |
| 2. | | |
| 3. | | |

4. Prognosis, Include Rehabilitation Potential:

5. History of Present Illness - Current Medical Symptoms/Conditions (Include pertinent past medical history)

6. Specific Physical Findings (Include pertinent positive and negative findings)

Height _____ Weight _____ Pulse _____ Blood Pressure _____

A. Vision and Hearing

B. Respiratory

C. Gastro-Intestinal

D. Genito-Urinary

E. Cardio-Vascular

F. Musculo-Skeletal

G. Neurological*

*(Findings must be documented if primary diagnosis is Dementia, Alzheimers or related condition)

7. Mental Findings: ☐ Alert ☐ Cooperative ☐ Psycho-Neurosis ☐ Psychosis ☐ Other

Is the individual competent to handle his/her own affairs? ☐ Yes ☐ No ☐ Questionable

A. Mental Status:

B. Psychological Test Results:

8. Pertinent Lab Findings: E.G., Hematology, Chemistry, EKG, X-Ray, EEG and other reports that substantiate condition. (Attach reports)

9. Diet (Results, if applicable):

10. Drugs Prescribed with Dosage and Frequency (Results, if applicable)

11. Recommended Therapy or Treatment Program or Regimen with Expected Duration:

12. Describe any Physical/Mental Conditions which would restrict work or training activities.
A. Temporary Condition(s): B. Permanent Condition(s):

13. Describe as fully as possible: Attach additional sheets as necessary

A. Limitations in activities of daily living:

B. Limitations in ability to work:

C. Specific restrictions of physical activity (Lifting, sitting, walking, standing, etc.)

14. If, in your professional judgement, this patient's physical and/or mental ability has been impaired or has deteriorated to the degree that he/she cannot be expected to function independently, please indicate below the type of service to allow state to make payment for client.)

- ☐ Homemaker Services
- ☐ Home Health Aide/Personal Care Aide Services
- ☐ Home Health Nursing Services
- ☐ Alternate Living Arrangement: Residential Care Facility, Adult Foster Home or Domiciliary Facility
- ☐ Nursing Facility Services (were needed at the time of admission and continue to be needed)
- ☐ Swing-bed services (in rural hospitals)
- ☐ ICF/MR Services
- ☐ Other (Please specify): _____

List all consultants and their specialities _____

How long has patient been under your care? _____
Date you last examined patient _____
Do you expect to continue treatment? _____

Signature of Examining Physician Date

15. Any Other Comments: